

NEONATAL SEPSIS MATERNAL FORM

Infant's Name: _____
 (Last, First, M.I.)
 Mother's Name: _____
 (Last, First, M.I.)
 Hospital Name: _____

Infant's Chart No.: _____
 Mother's Chart No.: _____

* Patient identifier information is NOT transmitted to CDC

1/19/05

NEONATAL SEPSIS MATERNAL FORM



SECTION I

STATEID _____ HOSPITAL ID (of birth; if home birth leave blank) _____

Infant Information

- Transferred or admitted to different hospital: ☐ yes ☐ no
 ! IF YES, hospital id of non-birth hospital: _____ AND
 ! date of admission: ____ / ____ / ____
 month day year (4 digits)
- Gestational age of infant in completed weeks: ____ (do not round up)

Maternal Information

- Maternal admission date & time: ____ / ____ / ____
 month day year (4 digits) time ☐ unknown
- Maternal age at delivery (years): ____ years
- Did mother have a prior history of penicillin allergy? ☐ yes ☐ no ☐ unknown
 ! IF YES, was a previous maternal history of anaphylaxis noted? ☐ yes ☐ no ☐ unknown
- Date & time membrane rupture: ____ / ____ / ____
 month day year (4 digits) time ☐ unknown
- Was duration of membrane rupture ≥ 18 hours? ☐ yes ☐ no ☐ unknown
- Did mother have rupture of membranes with or without labor before 37 weeks? ☐ yes ☐ no ☐ unknown
- If membranes ruptured at <37 weeks, did membranes rupture before onset of labor? ☐ yes ☐ no ☐ unknown
- Type of rupture: ☐ spontaneous ☐ artificial ☐ unknown
- Type of delivery: ☐ vaginal ☐ vaginal after previous C-section ☐ primary C-section ☐ repeat C-section
☐ forceps ☐ vacuum ☐ unknown
- If delivery was by C-section: Did labor or contractions begin before C-section? ☐ yes ☐ no ☐ unknown
 Did membrane rupture happen before C-section? ☐ yes ☐ no ☐ unknown
- Intrapartum fever ($T \geq 100.4$ F or 38.0 C): ☐ yes ☐ no ☐ unknown
 ! IF YES, 1st recorded $T \geq 100.4$ or 38.0 C at: ____ / ____ / ____
 month day year (4 digits) time

13. Were antibiotics given to the mother intrapartum? ☐ yes ☐ no ☐ unknown

! IF YES, answer a-d

a) Date & time antibiotics 1st administered: (before delivery)

____ / ____ / ____ ____
month day year (4 digits) time

b) Antibiotic 1: _____ ☐ IV ☐ IM ☐ PO # doses given before delivery: _____
Start date: ____/____/____ Stop date (if applicable): : ____/____/____

Antibiotic 2: _____ ☐ IV ☐ IM ☐ PO # doses given before delivery: _____
Start date: ____/____/____ Stop date (if applicable): : ____/____/____

Antibiotic 3: _____ ☐ IV ☐ IM ☐ PO # doses given before delivery: _____
Start date: ____/____/____ Stop date (if applicable): : ____/____/____

Antibiotic 4: _____ ☐ IV ☐ IM ☐ PO # doses given before delivery: _____
Start date: ____/____/____ Stop date (if applicable): : ____/____/____

Antibiotic 5: _____ ☐ IV ☐ IM ☐ PO # doses given before delivery: _____
Start date: ____/____/____ Stop date (if applicable): : ____/____/____

Antibiotic 6: _____ ☐ IV ☐ IM ☐ PO # doses given before delivery: _____
 Start date: __ __ / __ __ / __ __ __ __ Stop date (if applicable): : __ __ / __ __ / __ __ __ __

c) Interval between receipt of 1st antibiotic and delivery: _____ (hours) _____ (minutes)

d) What was the reason for administration of intrapartum antibiotics? (Check all that apply.)

☐ GBS prophylaxis ☐ C-section prophylaxis ☐ Mitral valve prolapse prophylaxis

☐ Suspected amnionitis ☐ Other ☐ Unknown